A Health Plan to Reduce Poverty

Alan Weil

Summary

Noting that the failures of the U.S. health care system are compounding the problems faced by low-income Americans, Alan Weil argues that any strategy to reduce poverty must provide access to health care for all low-income families.

Although nearly all children in families with incomes under 200 percent of poverty are eligible for either Medicaid or the State Children's Health Insurance Program (SCHIP), the parents of poor children often lack health insurance. Parents who leave welfare normally get a year of coverage but then lose coverage unless their employer provides it, and many employers of low-wage workers do not offer health insurance. Similarly, parents who take low-paying jobs to avoid welfare usually have no coverage at all. This lack of coverage discourages adults from working and may also affect the health of children because adults without health insurance are less likely to take their children for preventive care.

Weil proposes creating a federal earned income health credit (EIHC) and redefining the federal floor of coverage through Medicaid and SCHIP. His aim is to make health insurance affordable for low-income families and to make sure enough options are available that individuals and families can get coverage using a combination of their own, their employer's, and public resources.

Weil would expand Medicaid eligibility to include all families whose income falls below the poverty line. The EIHC would be a refundable tax credit that would be available to parents during the year in advance of filing a tax return. The credit, which would be based on taxpayer earnings and family structure, would phase in as earnings increase, reach a plateau, and then phase out farther up the income scale. The credit would be larger for families with dependents. The EIHC would function seamlessly with the employee payroll withholding system. It would be available only to adults who demonstrate that they had health insurance coverage during the year and, for adults with children, only if their eligible dependent children were enrolled in either a private or public insurance program.

Weil's proposal would cover individuals who receive coverage from their employer and those who do not. The proposal smooths transitions from public to private coverage, and it anticipates a substantial role for states. Weil estimates that his policy would cost about $45 billion a year.

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The many failures of the American health care system have badly exacerbated the financial and health-related hardship that low-income Americans face. Any comprehensive strategy to reduce poverty and improve the well-being of lower-income working families must include substantial changes in the way the nation pays for health care. Indeed one could argue that absent health care reform the United States is unlikely to undertake the many other important steps necessary to reduce poverty.

The Price of Health System Failures

Low-income Americans pay the price of health system failures in three ways. They pay through poor health and premature death, through personal financial hardship, and through lost opportunities for productive public investments that could improve their future prospects.

Health Consequences

The health of low-income Americans suffers because health insurance is not universally available. Of the more than 46 million nonelderly Americans without health insurance in 2005, 65 percent had family income at or below 200 percent of the federal poverty level ($39,942 for a family of four in 2005). An additional 16 percent of the uninsured had income between 200 and 300 percent of the federal poverty level.[1]

The importance of health insurance to good health has been well established. Although it is true that emergency care is available to all Americans, other types of care—preventive care, services that help people manage chronic conditions, diagnostic tests, and highly specialized care—are all hard to obtain without health insurance. Researchers have found that people who lack health insurance are less likely to get preventive care and services for chronic and acute conditions, even after personal characteristics (such as health status and education) that affect use of care, are taken into account. Again, taking into account these measurable differences between the populations, analysts find that the uninsured are sicker, more likely to suffer from chronic conditions, and more likely to die younger than people with health insurance.[2] And the consequences of a lack of insurance extend beyond the individual to burden entire families and communities.[3]

In an effort to contain the rising cost of health insurance, many employers have increased the deductibles and copayments in the coverage they provide their employees. Although these cost-sharing strategies reduce the premiums employers must pay, a growing body of research shows that they cause lower-income employees and their dependents to forgo necessary care, yielding negative health consequences, particularly for those trying to manage chronic conditions.[4] Recent efforts to encourage people to purchase high-deductible insurance plans and to use health savings accounts to cover the deductibles also place lower-wage workers at risk. Fourteen percent of those with high-deductible plans have no funds in their health savings account, and another 16 percent have less than $200.[5] The combination of high deductibles and depleted health savings accounts will lead to even more care forgone than the incremental increases in cost sharing that face other Americans.

Financial Consequences

Good health—one's own and one's family's—is a precursor to adequate earnings. People in fair or poor health have average earnings far below those who report that their health is

good or excellent.[6] Of course, poor health is both a cause and consequence of having low income, but good health care may offer a path to better health and higher earnings. The time required to care for a family member with a debilitating disease or a chronic condition makes it hard to work enough hours to earn one's way out of poverty. Having health insurance reduces the likelihood that a person leaving welfare will return to the rolls.[7]

Low-income Americans pay a heavy financial price for the nation's ailing health care system even when they are insured. Those who have insurance have a degree of financial protection, but the rising cost of coverage has made family budgets much tighter over recent decades. Between 2000 and 2005, median family income grew a total of 11 percent, from $50,732 to $56,194, with an annual growth rate of just over 2 percent.[8] During that same period, typical family insurance premiums rose almost 70 percent, from $6,200 to $10,400, with an annual growth rate of 11 percent.[9] Most economists believe that even though employers appear to subsidize their employees' health insurance, employees ultimately bear the cost through lower wages. If the money employers paid for more costly health insurance premiums had gone instead to workers' wages, median family income could have risen to as much as $60,400, an average annual growth rate of 3.5 percent—one and three-quarters times the 2 percent rate families experienced.

Even when Americans at the lower end of the income scale have insurance, they may find themselves "underinsured." Sixteen million people, or 9 percent, among those aged nineteen to sixty-four, have health insurance but are considered underinsured because they have inadequate financial protection against high health costs.[10] Underinsurance is most prevalent among those with incomes below 200 percent of poverty.[11] People with inadequate insurance may gain access to services, but at the cost of substantial financial hardship in the event of an illness or injury.

The financial burdens associated with health care are greatest for those without insurance.

Low-income Americans pay a heavy financial price for the nation's ailing health care system even when they are insured.

When confronted with illness they often pay the highest prices for services because they do not benefit from the negotiated discounts available to group payers.[12] If they are unable to pay, collection agency reports will harm their credit ratings, forcing them to pay higher interest rates when borrowing for other purchases. Ultimately they may face bankruptcy.

Lost Opportunities

Rising costs for Medicaid and Medicare have limited federal and state options for spending on other public priorities. The share of state general fund spending consumed by Medicaid increased from 15.1 to 16.2 percent between 1999 and 2003.[13] The combined federal cost of Medicare and Medicaid rose from 18.6 to 20.1 percent of total federal outlays over the same period (from $317 billion to $435 billion).[14] Given policymakers' reluctance to increase taxes, these trends have tightened public spending in other areas.

Long-term projections of Medicaid and Medicare cost growth have contributed to the sense that Americans cannot afford additional investments in antipoverty programs because they seem unable to afford the programs they already have. Congressional Budget Office projections over the next few decades are particularly gloomy. In the absence of policy changes that control these costs it is almost impossible to imagine government making major new investments in anything else.[15]

Goals of an Antipoverty Health Plan

In this article I set forth a proposal to meet the health care needs of low-income families. In view of the dozens of health care reform proposals already in circulation, some readers may wonder what yet another proposal can contribute. My aim is to place health reforms in the context of broader antipoverty policies, thus raising a somewhat different set of questions and considerations than those typically at the center of health policy discussions.

When putting together a reform proposal, health policy analysts generally begin with the goal of extending health insurance coverage to new populations or making health insurance coverage universal. They then impose a set of values related to issues such as patient choice or the role of government, along with assumptions (drawing on the available data) about such matters as the effects of regulations or financial incentives on individual and organizational behavior. The result is a proposal that meets health care–related objectives while adhering to certain values.

My proposal begins with a purely financial goal: to ensure access to health care services and provide financial protection to low-income families so they can work and devote their energies to the other tasks necessary for them to improve their financial and overall well-being. My proposal explicitly avoids (to the extent possible) some of the larger philosophical or ideological concerns that dominate health policy debates—taking as a given that Americans are closely divided on matters such as the appropriate role of government. Put differently, my proposal is by design politically incremental. It seeks to build on existing public and private coverage, not replace one with the other or fundamentally alter the nature of either.

What do low-income families need from health policy? At the most basic level they need affordable insurance that provides meaningful access to necessary health care services and financial protection against the burdens of illness and injury. But for health policy to meet a broader range of needs for low-income families, it must meet an additional challenge, one that generally receives less attention in policy discussions. Families need an effective range and ladder of options that meet changes in their circumstances without substantial disruption and without creating perverse financial incentives. For example, a young woman may be covered under her parents' insurance policy, lose that coverage on her nineteenth birthday, go to work for a small firm that does not offer coverage, become eligible for Medicaid when she becomes pregnant, and then lose coverage after the child is born. An effective health policy would bridge these gaps in coverage, providing continuity for the young woman without creating disincentives to work.

Current Policy Fails Working Families

High cost is the primary reason that health insurance is out of reach for so many working families. Yet many other aspects of the health

care system also make getting and keeping coverage difficult.

Most Americans get health insurance through the workplace. Although employer-sponsored insurance (ESI) is more widely available at higher income levels, it plays a major role throughout the income spectrum. Eighty-six percent of nonelderly people with incomes four times the poverty level or higher have ESI, but even 39 percent of people with incomes between 100 and 200 percent of poverty do also.[16]

Employers have complete discretion over whether to offer coverage, how much to subsidize the coverage, and the terms of that coverage.[17] Under federal law, states may not require employers to provide coverage.[18] Employer decisions vary by firm size, sector, average employee wage, and region of the country. Smaller firms are more likely to offer less generous policies that place a heavier financial burden on employees.

One-third of young adults aged eighteen to twenty-four are uninsured.[19] Among the next older group, adults aged twenty-five to thirty-four, 27 percent are uninsured.[20] Young families have relatively low incomes, which means they are less likely to have health insurance through their job. In the eighteen to twenty-four age group, only 47 percent have work-based insurance; the figure falls to 42 percent for those with only a high school diploma.[21]

Employer-sponsored insurance has become less prevalent over time. Employers gain tax advantages, as well as competitive advantages when hiring, if they provide health insurance coverage. But for many employers, especially smaller firms, these advantages are not enough to offset the cost of providing coverage. Data from 2005 show that although 98 percent of firms with 200 or more employees offer health insurance, only 59 percent of firms with 3 to 199 employees offer coverage—down from 68 percent in 2000.[22] The share of all workers in small firms who get insurance through their job fell from 57 percent to 50 percent between 2000 and 2005.[23] Thus any effort to fill in the gaps in employer-sponsored insurance must fight a strong tide.

Federal tax policy also works against low-income families. Workplace-based health insurance benefits are tax-exempt for the employer and the employee. The relatively low marginal tax rates for lower-wage workers mean that they receive smaller federal subsidies than higher-wage workers, even when their insurance benefits are identical. One study estimates that the tax benefits associated with employer-sponsored insurance, which totaled more than $188 billion in 2004, were heavily weighted toward the more affluent. Workers with family incomes greater than $100,000—14 percent of the population—received 26.7 percent of the benefit, while those with incomes less than $50,000—57.5 percent of the population—received only 28.4 percent.[24]

Although Medicaid and the State Children's Health Insurance Program (SCHIP) covered 46.5 million people in June of 2005, coverage varies substantially across states and by family structure.[25] Eligibility for public insurance is often on an individual basis—and extends much farther up the income scale for children than for adults. Through a combination of Medicaid and SCHIP, most states cover all children in families with income up to 200 percent of the federal poverty level; eight states do not extend eligibility that high and thirteen go higher. Eligibility for parents is quite variable, with many states capping eligi-

bility at a small fraction of the poverty level, although some cover parents with incomes as high as two or three times the poverty level. States cannot cover adults without children (unless they are disabled) through Medicaid at all without a waiver; only a few states have gotten such waivers, and they rarely cover adults with incomes above the poverty line.

This complex, patchwork system . . . creates perverse incentives as families are forced to trade off decisions that might improve their earnings against decisions that will allow them to keep their insurance.

By contrast, private employer-sponsored health plans are sold to subscribers—that is, to employees. Subscribers can then choose to cover their dependents (a spouse and children), but the dependents cannot get coverage through the workplace without the subscriber. It is possible for the children in a family to be covered by Medicaid or SCHIP and the working adult to have a substantial employer-provided subsidy for coverage and therefore be able to buy insurance for one, but if family coverage is out of reach, the spouse may be uninsured. Many other combinations of public, private, and uninsured status within a family are possible.

This complex, patchwork system not only leaves many working families without health insurance, it also creates perverse incentives as families are forced to trade off decisions that might improve their earnings against decisions that will allow them to keep their insurance. Medicaid offers the most dramatic example. Every state has a family income eligibility threshold for Medicaid. A person whose income exceeds that standard loses Medicaid coverage but is still likely to be in an income range where employer-sponsored insurance is only occasionally available. With a family insurance policy costing in excess of $10,000, the effective tax on the earnings that exceed the threshold is tremendous. The need to pay such a price for the increased earnings can serve as a strong work disincentive, or at best a severe penalty for advancing in a career.

State and federal policy reduce the size of the penalty in four ways. First, federal law provides for transitional Medicaid, which extends benefits for six or twelve months, depending upon the circumstances, when a person's income rises above the Medicaid eligibility threshold. But this benefit, which is underutilized, merely delays the penalty and does nothing to smooth the transition to private coverage. Second, federal law gives states the option of developing "medically needy" programs that allow people with incomes above the Medicaid threshold who incur substantial health costs to become eligible for assistance after they have "spent down" their excess resources. As of 2003, thirty-six states had elected this option. But although spend-down programs benefit those with substantial health costs, they do nothing to help low-income workers afford insurance coverage. Third, federal law and state choices have combined to increase the family income threshold for children's eligibility for public insurance beyond that for their parents. Thus, as a parent's income increases, the parent may lose coverage while the child retains it. Providing insurance for children reduces the effective marginal tax rate, but also

means that families have some uninsured members and does little to facilitate a transition to private coverage.[26]

Finally, more than a dozen states have adopted "premium assistance" programs in their Medicaid or SCHIP programs, or both, to cover the employee's share of the cost of an employer-sponsored plan. Despite great effort on the part of many states, most of these programs are quite small, and a variety of barriers impede their success. The most difficult to overcome are the limited availability of employer-sponsored insurance among the lower-income population, the challenges of engaging the small-business community in delivering a public benefit, and the need to ensure that participants in the premium assistance program have adequate coverage through a combination of their employer-sponsored insurance and any available wraparound services the state may need to provide. Although premium assistance programs provide a valuable benefit to participants, families still face a large financial burden once they lose their Medicaid or SCHIP eligibility and must pay their share of premium costs on their own.

The Advantages of Universal Coverage

Health policy analysts gravitate toward universal coverage strategies when describing reforms to the health care system. Leading policy analysts on both the right and the left of the political spectrum have developed coherent, rational universal coverage proposals that essentially scrap the current patchwork of coverage and replace it with something universal that fits with their values and views of the appropriate roles of government and individuals.[27]

Universal coverage plans can readily meet the various needs of low-income families. They ensure coverage for all, rely on financing systems that are equitable, and eliminate eligibility threshold penalties and perverse incentives. Indeed, many universal coverage proposals achieve their goals at a substantially lower "per person newly covered" cost than incremental expansions can.

Despite the advantages of universal coverage, however, the current political environment is more hospitable to incremental coverage expansions. After all, the corollary to designing a rational system is the need to unravel the many irrational aspects of the current system which, despite its many flaws, meets the needs of many Americans and serves as an engine for economic growth and profits. Doing so would arouse substantial resistance from those who are happy with the current system. Although my proposal is not as ambitious as some would prefer, it is designed to meet the key objective of improving access to health care for low-income Americans.

Requirements for an Incremental Expansion

For an incremental program to meet the needs of low-income families it must address three core problems in the current system: transitions, disincentives to work, and the lack of horizontal equity—that is, similar treatment of all people who are similarly situated.

A reformed system must allow for smooth transitions, particularly from public to private coverage as a person's earnings and job quality improve. Public programs ensure comprehensive benefits with very limited cost sharing. When they charge premiums, these are the same regardless of the health status of enrollees. Public programs have public oversight and consumer protection to a degree not generally found in private health insurance. Private coverage provides a range of

choices and opportunities for innovation. The higher provider payment rates that prevail in private insurance yield a broader range of networks and sites of care. The terms of coverage, however, are quite variable, and individuals or small firms may face high premiums because of age or poor health. The challenge for public policy is to bridge the gaps between these systems.

An effective policy must also minimize disincentives to work. Public subsidies for health insurance coverage, however, necessarily pose a substantial risk of such disincentives. In 2005 a typical health plan for a single employee cost $4,025, and family coverage ran $10,880.[28] If, for example, a reform proposal posits that a family should pay no more than 10 percent of its income for health insurance, then even a family earning $100,000 would require a subsidy to purchase family coverage. Subsidies reaching that income level are hard to imagine. A more realistic upper bound for receiving a subsidy is median family income, which was about $56,200 in 2005.[29]

Meanwhile, most health reform proposals start with the premise that people with income below poverty cannot afford to contribute at all to the cost of their coverage. If a benefit worth $10,000 is provided at no cost to a family with $20,000 annual income and is phased out completely at around $60,000 family income, the effective marginal tax rate associated with the phase-out is quite steep, at 25 percent ($10,000 ÷ [$60,000 – $20,000]). This high effective tax rate is particularly worrisome when viewed in conjunction with the effects of the phasing out of other benefits. In an effort to "make work pay," policymakers in 1996 combined welfare reform with a series of work supports that supplement wages when parents first go to work, but phase out slightly farther up the income scale.[30] If health benefits are phased out in the same range as the work supports—income supplements, child care subsidies, and housing subsidies—are also phasing out, the financial benefit of additional work can become quite limited. Work disincentives cannot be eliminated in a targeted program, but they should be kept as small as possible.

Finally, an effective policy for low-income families must stress horizontal equity over target efficiency.[31] Although 33 percent of nonelderly people with family incomes below twice the poverty level are uninsured, 26 percent of people in that category have private coverage through their work.[32] A targeted program would deliver subsidies only to those who "need" them—the uninsured—while doing nothing for the 26 percent who are struggling to afford their share of the premium or who have taken lower-paying jobs to obtain a health benefit. Penalizing people who do the "right thing" violates fundamental notions of fairness. Indeed, the imposition of such penalties by the now-defunct Aid to Families with Dependent Children program led to the view that it was flawed and needed to be replaced through welfare reform. One recent analysis concluded that, ironically, steps designed to limit SCHIP coverage to those without access to employer-sponsored coverage block enrollment more among people without access to such coverage than among those with it.[33] Ensuring horizontal equity, however, would put a higher price tag on the proposal. Politics might dictate a less expensive program, in which case some horizontal equity may be lost. But although such a program might be easier to enact, it would be harder to sustain.

A Proposal for Improving Access to Health Care

Low-income families would benefit from a higher, federally defined floor of public cov-

erage through Medicaid and SCHIP and a new federal earned income health credit that could be applied to the cost of coverage provided either by their state or by their employer. This combination of policies would help low-income families afford coverage while meeting the three goals of facilitating transitions across types of coverage, minimizing work disincentives, and providing equitable benefits to people who are similarly situated.

Proposal Overview

The proposal would first expand Medicaid eligibility to all people with family income below the federal poverty level and, through a combination of Medicaid and SCHIP, to all children with family income below twice the poverty level. The expansion for children would be modest—all but eight states already cover children up to or exceeding this level. The expansion for adults would be substantial. Only fourteen states and the District of Columbia cover parents living in poverty, and adults without children living with them are rarely eligible for Medicaid.[34] As is now the case with Medicaid, states would have the option of extending coverage farther up the income scale. The goal is not to make the Medicaid and SCHIP programs uniform across the country, but to create a clearly defined floor on which other sources of coverage can build.

The proposal would also create a new earned income health credit (EIHC) modeled on the well-regarded earned income tax credit (EITC).[35] The EIHC would be a refundable tax credit claimed each year on the federal tax return but, like the EITC, would be made available during the year in advance. The credit would be based on taxpayer earnings and family structure and would phase in as earnings increase, reach a plateau, and then phase out farther up the income scale. The credit would be larger for families with dependents, reflecting the higher cost of family coverage.

The EIHC could be used in either of two distinct ways. When applied to a state-sponsored plan, it would reduce the premium that the state would otherwise bill the participant for

The proposal would also create a new earned income health credit (EIHC) modeled on the well-regarded earned income tax credit (EITC).

providing coverage. When applied to an employer-sponsored plan, it would reduce the contribution the employee would otherwise have to make to participate in the employer's plan. The amount of the credit and the mechanism for obtaining it would differ, depending on the source of the coverage. The EIHC would not be available to people who purchase insurance in the individual or nongroup market.

How the EIHC Would Work with the State Plan

All states would be required to design and implement a mechanism that enables anyone who receives the EIHC to purchase health insurance. States could meet this requirement in a variety of ways. They could open up their existing Medicaid or SCHIP programs, or both, to this new population. They could anchor the program to other groups, such as state employees. Or they could develop new entities, like the Massachusetts Connector, which was created as part of that

state's recent health reforms to make subsidized insurance available to the low- and moderate-income population.[36] Whatever approach they choose, based on current practices, states are likely to contract with one or more private health insurance plans to provide the insurance. That is, the "state" insurance would generally be delivered through one or more private health plans.

Some states might develop an insurance product and make it available only to the target population of EIHC recipients. Other states might incorporate this effort into a larger initiative that markets products to small businesses or individuals whose incomes exceed the EIHC eligibility threshold. States could even consider supplementing the value of the federal EIHC with state funds to help targeted populations afford better coverage than they might otherwise be able to get.

The state insurance product would have to be community rated and guaranteed issue. That is, the price the enrollee is charged could vary by family size but not by age or health status, and no eligible applicant could be denied coverage. These requirements are essential to ensure that EIHC recipients get coverage, because the EIHC would not be any larger for older or sicker people than for those who are younger and healthy. Absent this requirement, people could find themselves with a subsidy that was too small to allow them to afford a suitable plan. In the extreme, some people with health conditions might not be able to find an insurance company that would sell them a plan at all.

The community-rating requirement adds a layer of complexity to the proposal. There is a significant risk that this new program would suffer from adverse selection—that is, it would attract those who could not get coverage elsewhere or who could get it elsewhere only at a high cost. Meanwhile, healthier, lower-cost populations would stay in the private market, where they could find lower prices. This risk has been discussed elsewhere in greater detail than is possible here.[37] In brief, the state plan is at greater risk if its rating rules differ from those in the market as a whole, if the subsidies are small, and if the program is less attractive in other respects than the broader market. These circumstances will vary from state to state. A few states already have tight rating rules similar to those that would exist for the new state product; most do not.

Ultimately, states would likely have five options to address concerns about adverse selection. First, they could examine their existing rules in the private market and bring them closer to community rating. Second, they could establish (or expand existing) high-risk pools or reinsurance mechanisms to try to segregate higher-risk populations from all markets into a separate, subsidized pool, thereby reducing the risk and burden in the state plan. Third, they could expand subsidies using state funds to reduce the potential for adverse selection. Fourth, they could open the state plan to a much larger share of the market, thereby diluting the effect of high-risk enrollees. Fifth, they could accept a certain amount of adverse selection and fund the excess risk from other resources.

How the EIHC Would Work with Employer Coverage

The EIHC would be designed to function seamlessly with the employee payroll withholding system. Employees would determine their expected credit by completing the appropriate forms. Employers would subtract the amount of the credit from the amount

they withhold from each employee's paycheck and remit to the federal government as taxes. The employer would bundle the credit with employer and employee contributions in a single payment to the health plan that provides insurance to the firm's employees. This process is described more fully in two reports that have examined the implementation of a tax credit that supports employer-sponsored insurance.[38]

Beneficiaries of the federal earned income tax credit can receive the credit in advance during the year through a similar payroll credit, though less than 1 percent of those eligible take advantage of this option.[39] Ensuring that EIHC beneficiaries use the advance option will require full integration of the EIHC with not only the employer's withholding system but also the employer's open enrollment and plan selection processes. The idea is to make applying for the EIHC, calculating the credit, and participating in an employer-sponsored plan a single event.

As with the EITC, the ultimate value of the EIHC will have to be calculated on the year-end tax return. If applicants claim a larger credit during the year than they are actually owed, they will have to pay the excess back to the Internal Revenue Service when they file their tax returns. Some proponents of health insurance tax credits have suggested dropping the reconciliation aspect entirely, so as not to discourage participation. Such a step, however, might undermine the integrity of the overall approach. It would be preferable to make it very unlikely that people who accurately report their income will owe money. One option would be to calculate the credit based on monthly income and health insurance participation. If employees were able easily and quickly to report status changes, such as family size or composition, the value of the credit could be adjusted automatically and immediately to reflect the change.

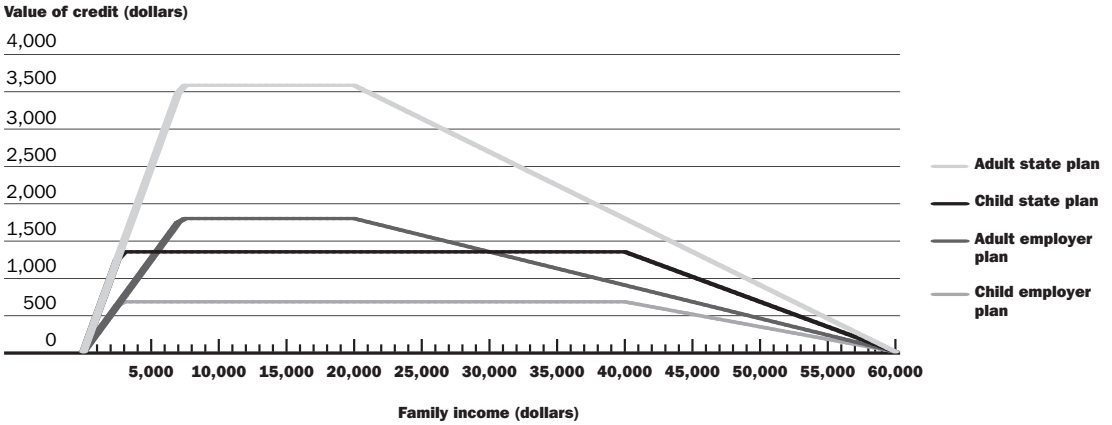
How the Value of the EIHC Would Be Established

Each tax filing unit would have two EIHC values: the maximum credit available and the credit it actually receives.[40] The maximum available credit would be calculated individually for each member of the tax filing unit and then summed to create a total value for the family. The EIHC would be available only to taxpayers who paid out of their own resources for a health insurance policy. All members of the tax filing unit would have to have coverage before the unit could claim the credit for anyone. A family whose children were eligible for and covered by Medicaid or SCHIP could claim the credit for the parents, but parents who did not secure coverage for their children would not be eligible for the credit at all. The EIHC value would be prorated on a monthly basis for those who had health insurance for a portion of the year.

The design and computation of the credit would be different for state-sponsored and employer-sponsored coverage. For state plans, the maximum and actual credits would be the same. The credit would be based on family income, with a design similar to that of the EITC. That is, the credit would phase in at 50 cents for each dollar of earned income, hit a plateau that would be sustained through the poverty level for adults and twice the poverty level for children, and then phase out to zero at three times the poverty level. The plateau would be set at 90 percent of the cost of a typical health plan, or roughly $3,600 for an adult.

The EIHC would reduce the price an enrollee pays for the public plan from its market value to a lower, subsidized level. The

Figure 1. Proposed Earned Income Health Credit



Note: Based on a federal poverty level of $20,000 for a family of four and a cost of coverage of $4,000 per adult and $1,500 per child.

plan would have a very low net price for those who receive the maximum EIHC, gradually rising to the unsubsidized amount as family income increased.

For employer-sponsored coverage, the maximum credit should be lower because most employees already receive a subsidy from their employer. Subsidies of less than 50 percent for employee-only coverage are extremely rare (only 4 percent of workers in small firms have subsidy rates this low).[41] Only 12 percent of all workers have family coverage subsidy rates lower than 50 percent, although the rate is 24 percent among workers in small firms.[42] It seems reasonable to use 50 percent as the starting point for the public subsidy as it will capture the large majority of people, whether they need individual or family coverage. Thus the maximum credit for the EIHC in employer-provided coverage would plateau at 45 percent of the cost of coverage, to reflect a 90 percent public subsidy when the employee contribution is 50 percent.

The maximum EIHC value is shown in figure 1. Many employees receive subsidies from their employer of more than 50 percent, and almost one-quarter of workers contribute nothing toward the cost of employee-only insurance coverage.[43] The maximum credit would thus exceed what these workers have to pay out of their own pocket for coverage. For reasons I discuss in more detail below, their EIHC would be calculated as follows. First, workers would receive the amount they contribute toward their coverage. In addition, one-sixth of the difference between their contribution and their maximum EIHC would be deposited on their behalf into a flexible spending account that could be applied toward the out-of-pocket costs the employee incurred during the year. The same amount would go to the employer as a credit against the cost of providing health insurance. Thus, the government would pay out a total of one-third of the amount by which the maximum credit exceeds the amount the worker has to pay.

How the Proposal Addresses the Challenges Facing Low-Income Families

My plan is designed to overcome the challenges facing low-income families by facilitat-

ing transitions across sources of coverage, minimizing work disincentives, and pursuing the goal of horizontal equity. It is also designed to minimize incentives for employers and employees to replace their current payments with public support.

The plan facilitates transitions by providing realistic options for new sources of coverage when another source ends. As the parent (or parents) in a family goes to work and income rises, the family will at some point exceed the income thresholds for the fully subsidized Medicaid program. If the parent works at a firm that offers health insurance coverage, the EIHC will be there to subsidize the share the employee is expected to pay, and in some circumstances subsidize part of the employer's cost as well. If there is no employer-sponsored coverage, the state plan is available, also on a subsidized basis. Movement across these forms of coverage will still involve some changes, but will avoid the penalties and discontinuities in today's health care system.

The plan minimizes work disincentives by trying to keep as low as possible the effective marginal tax rates families face as their earnings increase. Because the plan must meet the needs both of people without access to employer-sponsored coverage and of those who do have access and have widely varying rates of employer subsidy, achieving that goal is complicated. The design is best explained by considering three families, each with one worker, a nonworking spouse, and two children. In each family the worker earns $40,000 a year. In one family, the employer does not offer health insurance; in the second family, employer-provided coverage is available if the employee contributes 40 percent of the $10,000 cost of the plan; in the third family, workplace coverage is available with an employee contribution of 20 percent, or $2,000. Although all three families have the same income, their ability to obtain health insurance is quite different. If a family with income of $40,000 can afford to contribute 2.5 percent of its income, or $1,000, toward the cost of coverage, the first family faces a shortfall of $9,000, the second a shortfall of $3,000, and the third a shortfall of $1,000.

The plan is designed to overcome the challenges facing low-income families by facilitating transitions across sources of coverage, minimizing work disincentives, and pursuing the goal of horizontal equity.

A tax credit that treats all three families the same will be either inadequate or inefficient. If the credit is much less than $9,000, the first family will have inadequate coverage. If the credit is high enough to meet the first family's needs, the second and third families will receive much more than they need to get coverage.

A tax credit that exactly meets each family's needs would be adequate and appears to be efficient, but creates a different problem. If the second family receives a credit of $3,000 and the third family a credit of $1,000, the third family's employer has no incentive to continue providing such a generous subsidy toward coverage. The third employer could reduce its subsidy by $2,000 and the employee would be no worse off. In the extreme, both the second and third employers might choose to drop coverage entirely,

knowing the families would get a $9,000 credit, which would come close to meeting the family's financial needs for obtaining good coverage.

In fact, substantial barriers keep employers from making such radical changes.[44] But even having to replace some private dollars with public dollars would be expensive and could make the cost of the program, relative to the number of people who newly gain insurance coverage, unacceptably high.

Two features of the plan are designed to address these problems while still striving for equity. First, the large credit available to those without employer coverage can be used only to purchase a public plan, and the credit falls short of the value of a typical private plan. An employer who drops coverage entirely would leave the firm's employees substantially worse off with respect to insurance choices. Some employers might take this step nonetheless, but the plan is designed to minimize the likelihood that they will.

Second, the plan rebates a portion of the gap between each family's out-of-pocket premium costs and its EIHC maximum credit. An employer who offers generous subsidies would receive a modest rebate for the employees of the firm who are eligible for the EIHC. The employees also receive a modest rebate, which provides them with additional value associated with the employer contribution toward coverage even if they lose some of the value of the credit. Together these features should help discourage employers from reducing their contribution levels.

The plan also supports workers who are increasing their earnings. Consider two possible scenarios for the second worker. In the first, the worker gets a raise in cash salary from $40,000 to $42,000. In the second, the worker moves to a new job that gives the same salary but an increase in the employer subsidy for health insurance from $6,000 to $8,000, so that the worker's situation is now identical to that of the third worker. Both scenarios represent a $2,000 increase in the worker's total compensation, which public policy should support. As workers' earnings go up, their need for assistance falls, so some decline in support is appropriate. But the design of the credit should not "tax" away all of the increase or it will impede career advancement.

The first scenario moves the worker farther along the phase-out schedule of the EIHC (see table 1). The credit will decline at the rate of the phase-out, but the worker will be much better off after the raise. In the second scenario the employee will lose $1,150 in EIHC, because the value is capped at the actual amount the employee must pay. The employee and employer will each get a rebate of $192, which represents one-sixth of the amount by which the maximum EIHC exceeds the employee contribution to coverage. The employee in the second scenario faces a steeper marginal tax rate. However, the extra salary in scenario one is subject to payroll and income taxes that reduce the difference between the net effect of the two scenarios.

Although the policy goal is to keep marginal tax rates from becoming too large, a family may consider the situation somewhat differently. In its original circumstances, with a $40,000 salary and a $4,000 contribution toward coverage, the family must come up with $850 to purchase coverage. With a cash raise, the family now has substantially more resources available to make a slightly larger contribution. If the worker takes a job with a higher employer subsidy, he no longer needs to make a contribution out of his own pocket,

Table 1. Change in Family Well-Being from Increase in Salary or Decrease in Employee Health Insurance Contribution

Dollars except when otherwise noted

Item	Starting point	Scenario 1	Scenario 2
Annual salary/employee health insurance contribution	$40,000/$4,000	$42,000/$4,000	$40,000/$2,000
Maximum EIHC	3,150	2,835	3,150
Actual EIHC	3,150	2,835	2,000
Net contribution to coverage (rebate)	850	1,165	(192)
Family resources after contribution	39,150	40,835	40,192
Increase in resources relative to starting point		1,685	1,042
Effective marginal tax rate		15.8%	47.9%

Note: Based on federal poverty level of $20,000 for a family of four and structure of EIHC as described in text.

and he gains a small rebate to deposit into a flexible spending account. Either change is positive for the family, regardless of the precise marginal tax calculation.

Proposal Costs

The price tag of this proposal is sure to be quite high. A recent analysis placed the cost of expanding Medicaid to all adults with incomes below the poverty line at $24 billion in 2006, with the federal government bearing $14 billion of that cost and the states, $10 billion.[45] Most tax credit proposals have been on a much smaller scale than the one proposed here, and the cost estimates are quite sensitive to their structure. One tax credit proposal that was capped at 30 percent of the cost of insurance coverage was estimated to cost about $15 billion in 2005.[46] The Congressional Budget Office estimated the cost of a maximum credit of $2,750 for a family with a phase-out point of 300 percent of the federal poverty level to be $3.1 billion in 2008.[47] A far more ambitious and generous proposal that includes sliding-scale subsidies for people with incomes up to 400 percent of the federal poverty level to purchase employer-sponsored insurance was estimated to cost $27.1 billion in 2007.[48] This proposal included subsidies for purchasing nonemployer plans, at an estimated cost of $31.4 billion. Based on these figures, I estimate that my proposal will cost about $45 billion a year, with the federal government paying about $35 billion and the states, about $10 billion.

This cost estimate is very rough. A more precise estimate would require a much more sophisticated modeling approach. The dynamics of the health care system are such that small changes in policy variables can ripple through the system with large and unexpected effects. Models cannot perfectly anticipate those effects, but they provide important information that can be used to either prepare for the effects or modify the plan. In this proposal, small changes to the structure of the EIHC could yield large unexpected changes in employer and employee behavior and in overall cost. The proposal was designed with the intention of keeping those changes modest, but if modeling results suggested changes on a large scale, it would be worth considering modifying the proposal.

The cost could be brought down in many ways. The obvious options are to reduce the maximum value of the EIHC, make the phase-out steeper, or scale back the public

program expansion. Each would limit what the plan could achieve. Another option would be to put an age limit on eligibility for this new program. If the primary goal is to reduce poverty for low-income families, the policy could target younger adults and families. Such an approach would focus resources on the share of the uninsured that has, on average, lower costs, because health costs tend to increase with age.

In fact, it is reasonable to expect the proposal to raise overall health care spending because people without health insurance use about 60 percent as many services as those with insurance.

Variations on the Proposal

The proposal provides a credit of uniform value in a nation where health care and health insurance costs vary.[49] It will be relatively easy for people who live in low-cost regions to get good coverage, whereas those in regions with higher costs may find the credit inadequate to purchase a good policy. Some reform proposals vary the credit by the underlying cost of insurance. This adds a substantial layer of complexity and creates some troubling incentives for the health system as a whole (the more expensive you are, the more you get paid).

Similarly, the credit value could vary by the age or health status of the applicant. This would avoid the risk-selection problems already noted, but would be extremely difficult to administer. Alternatively, the proposal could mandate that states adopt community rating policies for health insurance. This would solve the risk-selection problems, but create other disruptions within the current health insurance market. It would also fundamentally alter the balance between state and federal power in health insurance regulation—a change to which the states would be sure to object.

Finally, the proposal could have provided an option for people to receive the EIHC if they purchase coverage in the individual insurance market. Such a structure provides less of an assurance that the insurance policies will be adequate, is far more prone to the substitution of private dollars with public dollars, and requires the creation of an entirely new administrative structure to enable the credit to flow to families.

Conclusion

My proposal is designed to make health insurance a viable option for all Americans with low or moderate income. It builds on existing public programs and private sector coverage.

The proposal is designed with an implicit affordability calculation in mind. That is, it begins with the notion that it is reasonable to expect individuals and families at a certain income level to pay a modest share of their income toward health insurance coverage. The EIHC provides the subsidy that brings the net cost for the family down from the market price to the affordable price. The implicit affordability calculation is rough—some people will still view coverage as unaffordable at these subsidized prices; others would have purchased coverage anyway, even if it had cost them more. Those who still find insurance unaffordable even after

the subsidies are applied and those who value other priorities more than they value having insurance coverage will remain uninsured. A more generous EIHC could be offered that would help more people at a greater cost to taxpayers. The EIHC could also be calibrated more closely to other factors that might influence a family's ability to afford coverage. Public programs routinely do this through income disregards—for example, by deducting child care or transportation costs from family income when determining program eligibility. However, the information collected on the tax return does not lend itself to such calibration.

While seeking to build a solid floor of public coverage, the proposal does not smooth out the major differences in how states regulate the health insurance market. In states with limited regulation, individuals and firms with employees with certain health conditions may find that they cannot obtain coverage at anything near the average prices used to develop the EIHC. Rather than seeking to standardize state insurance regulation, the plan requires every state to operate a plan that is available to everyone. Such a plan will cost states with limited regulation more than it will cost states with tighter regulation because the state program is more likely to attract sicker people when the private market charges higher rates to sicker people.

Ultimately, this proposal is not designed to reduce or control the rate of growth of health care or health insurance costs, nor is it designed to improve the quality of health care. In fact, it is reasonable to expect the proposal to raise overall health care spending because people without health insurance use about 60 percent as many services as those with insurance. Cost containment and quality improvement are critical issues for the health care system as a whole and they warrant far more attention than can be given in a brief paper focused on insurance coverage.

The proposal made here would not solve all that ails the American health care system. It would, however, make coverage more nearly affordable and accessible to all, especially poor families. It would ease the concerns of lower-income families about health insurance and access to health care services. It would enable these families to focus on advancing their careers and taking care of their children, rather than on trying to navigate a system that falls short in so many ways. And finally, it would reduce the disincentives for poor families to work and thereby increase the odds that they could earn their way out of poverty.

Notes

1. Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America 2005 Data Update* (Washington, November 2006), p. 14.

2. Committee on the Consequences of Uninsurance, Institute of Medicine, *Coverage Matters* (Washington: National Academies Press, 2001).

3. Committee on the Consequences of Uninsurance, Institute of Medicine, *A Shared Destiny: Community Effects of Uninsurance* (Washington: National Academies Press, 2003).

4. Amy Davidoff and Genevieve Kenney, *Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey* (Washington: Urban Institute, May 2005), p. 4.

5. Paul Fronstin and Sara R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience with High-Deductible and Consumer-Driven Health Plans,* Issue Brief 300 (Washington: Employee Benefit Research Institute, December 2006), p. 27.

6. Jack Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* 60, no. 2 (June 2003): 3S–75S.

7. Pamela Loprest, "Who Returns to Welfare?" Assessing the New Federalism, no. B-49 (Washington: Urban Institute, September 2002), p. 5.

8. U.S. Census Bureau, "Historical Income Tables—Families," www.census.gov/hhes/www/income/histinc/f08ar.html (accessed March 20, 2007).

9. Kaiser Family Foundation and Health Research Educational Trust, *Employer Health Benefits 2005 Annual Survey* (Menlo Park, Calif., September 2005), p. 61.

10. Cathy Schoen and others, "Insured but Not Protected: How Many Adults Are Underinsured?" *Health Affairs* web exclusive (June 14, 2005) http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.289v1 (accessed February 28, 2007). The authors define underinsurance to include one or more of the following: (1) medical expenses of 10 percent or more of income; (2) among low-income adults (those with incomes below 200 percent of the federal poverty level), medical expenses of 5 percent or more of income; (3) health plan deductibles equal to or exceeding 5 percent of income.

11. Ibid.

12. Committee on the Consequences of Uninsurance, *Coverage Matters* (see note 2).

13. Based on National Association of State Budget Officers, *State Health Expenditure Report 1998–1999* and *2002–2003*, www.nasbo.org/publications.php (accessed February 22, 2007).

14. Based on Congressional Budget Office, *Historical Budget Data*, www.cbo.gov/budget/historical.shtml (accessed February 22, 2007).

15. Joseph R. Antos and Alice M. Rivlin, "Rising Health Care Spending—Federal and National," in *Restoring Fiscal Sanity 2007: The Health Spending Challenge,* edited by Antos and Rivlin (Brookings, 2007).

16. Kaiser Commission, *Health Insurance Coverage in America* (see note 1), p. 1.

17. States can and do regulate the types of products insurance companies can sell. When an employer purchases coverage from an insurance company it is subject to these regulations. Larger firms generally self-

insure (bear their own financial risk). Since they are not purchasing a regulated product, they are not subject to the terms a state may establish for insurance policies.

18. Since 1975, Hawaii has had in place an "employer mandate" that all firms provide coverage to their employees (but not the employees' dependents). Congress provided Hawaii with explicit permission to adopt this policy, but it is not available to any other state.

19. U.S. Census Bureau, *Current Population Survey, Annual Social and Economic Supplement, 2006*, www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed February 22, 2007).

20. Ibid.

21. Ibid.

22. Kaiser and HRET, *Employer Health Benefits 2005 Annual Survey* (see note 9), p. 35.

23. Ibid., exhibit 3.1.

24. John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* web exclusive (February 25, 2004), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.106v1 (accessed March 2, 2007).

25. Kaiser Family Foundation, Statehealthfacts.org, www.statehealthfacts.org (accessed March 20, 2007). Note that this point-in-time measure differs from a count of people who were ever enrolled in a program in a year.

26. In some instances a family may face three or more different eligibility levels. Children's eligibility levels often vary by age, so that two children may be in separate programs (one in Medicaid, one in SCHIP) or one may be covered and the other uninsured, while the parents face yet another eligibility threshold.

27. For one compilation of ten such proposals, see Jack A. Meyer and Elliot K. Wicks, eds., *Covering America: Real Remedies for the Uninsured* (Washington: Economic and Social Research Institute, June 2001).

28. Kaiser and HRET, *Employer Health Benefits 2005 Annual Survey* (see note 9).

29. Census Bureau, "Historical Income Tables–Families" (see note 8).

30. Gregory Acs and others, "Does Work Pay? An Analysis of the Work Incentives under TANF," Assessing the New Federalism, Occasional Paper 9 (Washington: Urban Institute, 1998).

31. A discussion of this trade-off appears in Linda J. Blumberg, "Balancing Efficiency and Equity in the Design of Coverage Expansions for Children," *Future of Children* 13, no. 1 (Spring 2003).

32. Derived from Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer* (Washington: Kaiser Commission, October 2006), table 4, 31.

33. Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" Working Paper 12858 (Cambridge, Mass.: National Bureau of Economic Research, January 2007).

34. Kaiser Family Foundation, "Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2006," www.statehealthfacts.org.

35. Steve Holt, "The Earned Income Tax Credit at 30: What We Know," Research Brief (Metropolitan Policy Program, Brookings, February 2006).

36. For a good description of the Massachusetts reform, see John E. McDonough, "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* web exclusive 25, no. 6 (September 14, 2006) http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w420.

37. Rick Curtis and Ed Neuschler, "Insurance Markets: What Health Insurance Pools Can and Can't Do," Issue Brief (Oakland, Calif.: California HealthCare Foundation, November 2005).

38. Alan Weil, "Implementing Tax Credits for Affordable Health Insurance Coverage" (Boston: Blue Cross/Blue Shield of Massachusetts Foundation, October 2005); and Lynn Etheredge and others, "Administering a Medicaid + Tax Credits Initiative" (Washington: Health Insurance Reform Project, February 2007).

39. U.S. General Accounting Office, "Earned Income Tax Credit: Advance Payment Option Is not Widely Known or Understood by the Public," GAO/GGD-92-26 (February 1992); U.S. Department of the Treasury, "Taxpayers Were Assessed Additional Tax for Advance Earned Income Credit Payments not Received," Memorandum for Commissioner, Wage and Investment Division, 2003-40-126 (June 2003).

40. Tax filing units, insurance units, coverage categories for public programs, and families all take different forms that are sometimes aligned but often not. How to handle the differences between these concepts requires more attention than it is given in this paper. Some discussion of this topic appears in Weil, "Implementing Tax Credits for Affordable Health Insurance Coverage" (see note 38). For the sake of simplicity, this paper uses the term *family* for all of these categories.

41. Kaiser and HRET, *Employer Health Benefits 2005 Annual Survey* (see note 9).

42. Ibid.

43. Ibid.

44. Most firms have a heterogeneous mix of salaries and family circumstances among their employees. IRS rules prohibit discrimination across employees on benefits, so a change in employer contributions could not be focused exclusively on the subset of employees who would obtain a tax credit. In addition, compensation provided in the form of benefits receives certain advantages in the tax code. Still, if the financial incentives are strong, some nontrivial number of firms can be expected to change their behavior.

45. John Holahan and Alan Weil, "Toward Real Medicaid Reform," *Health Affairs* web exclusive 26, no. 2 (February 23, 2007), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.2.w254.

46. John Sheils, Paul Hogan, and Randall Haught, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy" (Washington: Lewin Group, October 18, 1999), www.lewin.com/NR/rdonlyres/BD11A6A0-1A58-4E87-94F5-C66A3CAFE50F/0/NCHC_Tax_Credit_Paper.pdf.

47. Congressional Budget Office, *Budget Options* (February 2007), p. 158.

48. Federation of American Hospitals, "Health Coverage Passport," www.fahs.com/passport/HCP%20PPT%20Designed%202-16-07.pdf (accessed March 20, 2007).

49. The average annual health insurance premium for family coverage varied by a factor of 1.22 between the highest and lowest among the ten largest states in 2004. However, most states were clustered quite close to the national mean. James M. Branscome, "State Differences in the Cost of Job-Related Health Insurance, 2004," Statistical Brief 135 (Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, July 2006).